Refugee health

Epidemiological paradox

The refugee experience

- Each individual experience is very particular:
- Within their countries there are significant differences: language, dialect, culture, religious backgrounds, exposure to traumatic events, etc
- Some refugees never have seen their “country of origin”
- The refugee camp is not a camp

Screening

- Tuberculosis
- HIV
- Hepatitis B and C
- Parasitic infections
- STDs: Syphilis, gonorrhea, chlamydia, Herpes, genital warts
- Malaria

Tuberculosis Screening

- In individuals 5 and older: Quantiferon test
- In children under 5 we test with PPD
- Active TB is uncommon
- Latent Tuberculosis infection is currently treated with rifampin for 4 months

HIV

- All individuals diagnosed with HIV infection were from African countries, predominantly the Democratic Republic of Congo

Infectious Hepatitis

- Hepatitis B is the most prevalent condition
- Most likely the transmission is sexually or vertical during delivery
- Hepatitis C screening is using the antibody reflexed to PCR
- We are currently treating Hep C in the primary care setting
- We don’t test for hep A

Parasitic infections

- We don’t do universal testing
- We test patients with symptoms and significant eosinophilia

STD

- We test syphilis serology for children 2 and older
- GC and chlamydia is tested for women having PAPs
- We do physical exam including genital exam to all males and females that are older than 18 or are sexually active

Screening

- Blood count
- Lead screening
- Micronutrient screening
- Cancer screening
- Chronic disease screening
- Mental health screening : Depression, Anxiety, PTSD

Barriers

- Cultural competence
- Language Access: Use trained interpreters
- Health disparities: Access, financial disincentives, diversify health care workforce
- Navigation of healthcare system
- Social Services : Cash and medical assistance, employment
- Mental health

Mental Health

- Screening and treatment of mental health problems is suboptimal: multiple reasons but especially lack of evidence –based interventions
- Higher rates of depression and anxiety
- Higher rates of suicide
- Somatization and health care utilization
- PTSD
- Substance abuse
- Prevalence is related to trauma exposure and post-migration socio-economic factors

Suicide prevention

- Improve sense of belonging and meaning
- Community building
- Gatekeeper model: Those who are in contact with refugee regularly can be trained to identify and refer people at risk
- Treat people with mood disorder, people with previous suicidal attempt and those who are having suicidal ideation

PTSD

- Trauma story: Know your patient: The greatest source of pain. Takes time. Avoid details. Show empathy.
- Psychological states: Humiliation, anger, revenge/hatred and hopelessness/despair
- Emotional States: “emotional firestorm”
- Physical illnesses: HTN, cardiovascular disease, diabetes, premature death
- Avoid over-medicalizing mental health

PTSD

- How to help to have purpose of life in the USA-Fargo
- Financial problems, social isolation
- Pain is always real: Avoid unnecessary testing/imaging. No correlation between anatomy and chronic pain
- When using meds focus on practical benefits: sleep, energy, reduced nightmares
- Legal concerns:

Practical Points

- Learn about their particular refugee experience.
- Greet in their language: even if you sound funny
- Use medically trained interpreters
- Give bad news face to face
- For mental health diagnosis: Use symptoms
- Develop clinical guidelines and best practice orders
- Use community health workers: Time for certification?